



Facility Name & ID Number APOSTOLIC CHRISTIAN HOME# 0021493 Report Period Beginning: 01-01-08 Ending: 12-31-08

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,643	7,413	1,460	18,516	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,643	7,413	1,460	18,516	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.16%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

OUTPATIENT PART B THERAPYF. Does the facility maintain a daily midnight census? YES

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 05/05/1975

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 32 and days of care provided 1,460Medicare Intermediary WISCONSIN PHYSICIAN SERVICE (WPS)

## IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 01-01-08 Ending: 12-31-08

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	263,119	21,418	20,267	304,804		304,804		304,804		1
2	Food Purchase		161,476		161,476		161,476	(9,204)	152,272		2
3	Housekeeping	149,303	1,652	2,828	153,783		153,783		153,783		3
4	Laundry	70,151	3,464	249	73,864		73,864		73,864		4
5	Heat and Other Utilities			82,155	82,155		82,155		82,155		5
6	Maintenance	59,281	30,932	46,018	136,231		136,231		136,231		6
7	Other (specify):*		7,107	146,881	153,988		153,988	(153,988)			7
8	<b>TOTAL General Services</b>	<b>541,854</b>	<b>226,049</b>	<b>298,398</b>	<b>1,066,301</b>		<b>1,066,301</b>	<b>(163,192)</b>	<b>903,109</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,467,928	148,262	62,372	1,678,562		1,678,562		1,678,562		10
10a	Therapy	93,829	1,338	8,511	103,678		103,678		103,678		10a
11	Activities	87,943	10,354	1,053	99,350		99,350		99,350		11
12	Social Services	44,069	(10)		44,059		44,059		44,059		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,693,769</b>	<b>159,944</b>	<b>71,936</b>	<b>1,925,649</b>		<b>1,925,649</b>		<b>1,925,649</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	72,632			72,632		72,632		72,632		17
18	Directors Fees										18
19	Professional Services			16,897	16,897		16,897		16,897		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	135,953	5,060	31,198	172,211		172,211		172,211		21
22	Employee Benefits & Payroll Taxes			524,212	524,212		524,212		524,212		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,072	47,072		47,072		47,072		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>208,585</b>	<b>5,060</b>	<b>619,379</b>	<b>833,024</b>		<b>833,024</b>		<b>833,024</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,444,208</b>	<b>391,053</b>	<b>989,713</b>	<b>3,824,974</b>		<b>3,824,974</b>	<b>(163,192)</b>	<b>3,661,782</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME #0021493 Report Period Beginning: 01-01-08 Ending: 12-31-08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			361,601	361,601	361,601	(158,626)	202,975				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,956	40,956	40,956	(25,711)	15,245				32
33	Real Estate Taxes			608	608	608	(608)					33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			403,165	403,165	403,165	(184,945)	218,220				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			9,628	9,628	9,628		9,628				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,490	33,490	33,490		33,490				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			43,118	43,118	43,118		43,118				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,444,208	391,053	1,435,996	4,271,257	4,271,257	(348,137)	3,923,120				45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

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**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,204)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(25,711)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (34,915)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(313,222)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (313,222)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (348,137)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		42,176	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 42,176		47

BHF USE ONLY					
48		49		50	51
					52

APOSTOLIC CHRISTIAN HOME

ID# 0021493

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	NON-ALLOWABLE REAL ESTATE TAXES	\$ (608)	33	1
2	COUNTRY VIEW EXPENSES	(122,284)	7	2
3	COUNTRY VIEW DEPRECIATION	(33,738)	30	3
4	DUPLEX EXPENSES	(31,704)	7	4
5	DUPLEX DEPRECIATION	(124,888)	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(313,222)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,204)	0	0	0	0	0	0	0	0	0	0	(9,204)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(153,988)	0	0	0	0	0	0	0	0	0	0	(153,988)	7
8	<b>TOTAL General Services</b>	<b>(163,192)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(163,192)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(163,192)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(163,192)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08 Ending:

Summary B

12-31-08

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(158,626)	0	0	0	0	0	0	0	0	0	0	(158,626)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,711)	0	0	0	0	0	0	0	0	0	0	(25,711)	32
33	Real Estate Taxes	(608)	0	0	0	0	0	0	0	0	0	0	(608)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(184,945)</b>	<b>0</b>	<b>(184,945)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(348,137)</b>	<b>0</b>	<b>(348,137)</b>	<b>45</b>									

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE	NONE					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 01-01-08 Ending: 12-31-08

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	NONE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

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**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	MORTON COMMUNITY		X	WORKING CAPITAL-STATE	VARIOUS	Various	ZERO	487,180	Various	6.0000	15,245	6								
7	BANK			SHORTFALL								7								
8												8								
9	TOTAL Facility Related						\$ 487,180				\$ 15,245	9								
<b>B. Non-Facility Related*</b>																				
10	COMMERCE BANK		X	CNTRY VIEW BLBG. LOAN	\$7,800.00	3/28/2000	875,000	435,120	04/10/15	5.4300	25,711	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$7,800.00		\$ 875,000	\$ 435,120			\$ 25,711	14								
15	TOTALS (line 9+line14)						\$ 875,000	\$ 922,300			\$ 40,956	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line #           

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2																													
3. Under or (over) accrual (line 2 minus line 1).			\$	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7																													
Real Estate Tax History:																																	
Real Estate Tax Bill for Calendar Year:		<table border="1"> <tr><td>2003</td><td>_____</td><td>8</td></tr> <tr><td>2004</td><td>_____</td><td>9</td></tr> <tr><td>2005</td><td>_____</td><td>10</td></tr> <tr><td>2006</td><td>_____</td><td>11</td></tr> <tr><td>2007</td><td>_____</td><td>12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	_____	10	2006	_____	11	2007	_____	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	_____	8																															
2004	_____	9																															
2005	_____	10																															
2006	_____	11																															
2007	_____	12																															
<b>FOR BHF USE ONLY</b>																																	
13	FROM R. E. TAX STATEMENT FOR 2007 \$	13																															
14	PLUS APPEAL COST FROM LINE 5 \$	14																															
15	LESS REFUND FROM LINE 6 \$	15																															
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																															
<b>All Real Estate Taxes are non-allowable and are adjusted out of Schedule V</b>																																	

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME APOSTOLIC CHRISTIAN HOME COUNTY WOODFORD

FACILITY IDPH LICENSE NUMBER 0021493

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493 Report Period Beginning:

01-01-08 Ending:

12-31-08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 33,601 B. General Construction Type: Exterior BRICK Frame BLOCK & WOOD Number of Stories ONE

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APOSTOLIC CHRISTIAN HOME OF ROANOKE DUPLEXES - 20 UNITS

APOSTOLIC CHRISTIAN HOME OF ROANOKE COUNTRY VIEW APARTMENTS - INDEPENDENT LIVING UNITS - 14 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>BLDG. AND GROUNDS</u>	<u>100,000</u>	<u>1975</u>	<u>\$ 35,875</u>	1
2					2
3	<b>TOTALS</b>	<b>100,000</b>		<b>\$ 35,875</b>	<b>3</b>

Facility Name & ID Number **APOSTOLIC CHRISTIAN HOME**

# **0021493**

Report Period Beginning:

**01-01-08**

Ending:

**12-31-08**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	61		1975	1958	\$ 202,000	\$	30	\$	\$	\$ 202,000	4
5			1976	1976	22,708		30			22,708	5
6			1991	1991	671,286	22,376	30	22,376		382,257	6
7			1992	1992	129,607	4,469	30	4,469		73,738	7
8											8
<b>Improvement Type**</b>											
9		Land & Bldg Improvements		1976	105,004						9
10				1977	6,591						10
11				1978	10,960						11
12				1979	9,124						12
13				1980	8,166						13
14				1981	6,506						14
15				1982	18,087						15
16				1983	36,023						16
17				1984	12,947						17
18				1985	13,333		VARIOUS			577,013	18
19				1986	8,595						19
20				1987	87,248						20
21				1988	43,526						21
22				1989	64,604						22
23				1990	11,217						23
24				1991	3,700						24
25				1992	5,410						25
26				1993	36,135						26
27				1994	14,661						27
28				1995	30,372						28
29		Soiled Utility Remodeling		1996	680					680	29
30		Fixed TV Monitoring System		1996	278					278	30
31		Remodel 14 East		1996	2,781					2,781	31
32		New Sidewalk		1996	1,375					1,375	32
33		Room Remodeling (9,21,17)		1997	11,487					11,487	33
34		Room Remodeling (11,8,10,19,5,6)		1997	17,049					17,049	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name &amp; ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FIRE ALARM SYSTEM COSTS	1998	\$ 12,671	\$	7	\$	\$	\$ 12,671	37
38	ROOM REMODELING (3,12,14)	1998	13,953		7			13,953	38
39	GAS LINE WORK	1998	1,033		7			1,033	39
40	PARKING LOT	1998	19,397		7			19,397	40
41	COURTYARD	1998	15,971		7			15,971	41
42	FIRE ALARM SYSTEM COSTS	1999	87,698		7			87,698	42
43	CALL LIGHT SYSTEM COSTS	1999	40,500		7			40,500	43
44	EAST ROOM REMODELING	1999	23,345		7			23,345	44
45	PT RESTROOM REMODELING	1999	605		7			605	45
46	MULTI-PURPOSE ROOM REMODELING	1999	1,438		7			1,438	46
47	SPRINKLER SYSTEM ADDITIONS	1999	3,166		7			3,166	47
48	STORM SEWER WORK	1999	2,396		7			2,396	48
49	DOOR ALARM SYSTEM	1999	2,075		7			2,075	49
50	WEST STATION ARCHITECT FEES	1999	4,742		7			4,742	50
51	EAST SIDE STATION REMODELING	2000	43,536		7			43,536	51
52	WEST SIDE STATION	2000	4,637		7			4,637	52
53	CALL LIGHT SYSTEM COSTS	2000	11,500		7			11,500	53
54	DOOR ALARM SYSTEM REMODEL	2000	2,093		7			2,093	54
55	RESIDENT ROOM REMODEL	2000	7,066		7			7,066	55
56	LANDSCAPING	2000	3,152		7			3,152	56
57	WATER MAIN EXTENSION	2000	1,675		7			1,675	57
58	SPRINKLER WORK	2001	19,622	1,403	7	1,403		19,622	58
59	NURSING AND SOCIAL SERVICE OFFICES	2001	1,587	112	7	112		1,587	59
60	NEW PARKING AREA	2001	2,363	172	7	172		2,363	60
61	ROOM REMODELING (12W)	2001	2,612	188	7	188		2,612	61
62	NEW WATER LINES	2001	4,581	330	7	330		4,581	62
63	ROOM REMODELED (8W)	2001	3,422	250	7	250		3,422	63
64	TUB ROOM ROOF	2001	27,941	1,993	7	1,993		27,941	64
65	WEST TUB REMODEL	2001	25,454	1,820	7	1,820		25,454	65
66	EAST HALL REMODEL	2001	23,052	1,647	7	1,647		23,052	66
67	EAST PARK AREA	2001	1,687		7			1,687	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,006,430	\$ 34,760		\$ 34,760	\$	\$ 1,706,336	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,006,430	\$ 34,760		\$ 34,760	\$	\$ 1,706,336	1
2	VINYL FLOORING - HSKG	2002	1,001	143	7	143		930	2
3	NURSING OFFICE	2002	1,068	152	7	152		988	3
4	EAST HALL REMODEL	2002	12,749	1,821	7	1,821		12,369	4
5	DELAYED EGRESS LOCK	2002	1,934	276	7	276		1,794	5
6	ROOM 5 REMODEL	2002	2,999	428	7	428		2,782	6
7	ROOM REMODEL	2002	3,173	453	7	453		2,945	7
8	WATER LINE REPAIRS	2002	15,959	2,280	7	2,280		14,820	8
9	TUB ROOM REMODEL	2002	235,862	33,695	7	33,695		219,017	9
10	WEST NURSES STATION	2003	21,472	3,067	7	3,067		16,869	10
11	WATER LINE REPAIRS	2003	4,424	632	7	632		3,476	11
12	ROOM REMODEL - 2 ROOMS	2003	3,808	543	7	543		2,987	12
13	NORTH CEILING REPAIR	2003	2,980	425	7	425		2,338	13
14	MIXING VALVES	2003	679	97	7	97		533	14
15	BASEMENT STAIRS	2003	6,956	994	7	994		5,467	15
16	CANOPY SPRINKLER	2003	1,425	204	7	204		1,121	16
17	ALARM SYSTEMS	2003	3,017	431	7	431		2,370	17
18	MECHANICAL ROOM WORK	2003	2,907	415	7	415		2,282	18
19	SPRINKLER IMPROVEMENTS	2003	6,428	918	7	918		5,049	19
20	LANDSCAPING SIDEWALK	2003	4,741	677	7	677		4,130	20
21	DRYWALL REPAIR/FIRE DRYWALL	2004	13,476	1,925	7	1,925		8,662	21
22	FIRE DAMPERS	2004	2,100	300	7	300		1,350	22
23	EXIT LIGHTS	2004	4,011	573	7	573		2,578	23
24	DRAIN LINES - EAST WING	2004	1,504	214	7	214		963	24
25	ELEVATOR WORK	2004	8,359	1,194	7	1,194		5,373	25
26	CONCRETE EXIT	2004	850	121	7	121		545	26
27	NORTH BASEMENT IMPROVEMENTS	2004	15,554	2,222	7	2,222		9,999	27
28	FENCING	2004	10,980	1,569	7	1,569		7,060	28
29	PLUMBING UPDATE	2004	3,949	564	7	564		2,538	29
30	KITCHEN FLOOR	2004	3,713	530	7	530		2,385	30
31	GENERATOR SHED - ELECTRIC	2004	2,380	340	7	340		1,530	31
32	BASEMENT ELECTRIC PANELS	2004	1,056	150	7	150		675	32
33	WEST HALL & DINING ROOM	2004	6,600	943	7	943		4,243	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,414,544	\$ 93,056		\$ 93,056	\$	\$ 2,056,504	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,414,544	\$ 93,056		\$ 93,056	\$	\$ 2,056,504	1
2	KITCHEN STEAMER WIRING	2004	614	88	7	88		396	2
3	MAINTENANCE SHED	2004	34,020	4,860	7	4,860		21,870	3
4	CANOPY SPRINKLER REPAIR	2004	2,696	385	7	385		1,732	4
5	NEW FLOOR 18W	2005	1,750	250	7	250		875	5
6	DRYWALL STATE SURVEY	2005	8,016	1,145	7	1,145		4,007	6
7	AC RELOCATE	2005	448	64	7	64		224	7
8	WEST SIDE PLUMBING	2005	4,108	587	7	587		2,054	8
9	DINING REMODEL	2005	67,687	9,670	7	9,670		33,845	9
10	WATER LINE REPAIR	2006	728	104	7	104		260	10
11	DINING INSTALLATION	2006	850	121	7	121		303	11
12	WEST FLOOR JOIST WORK	2006	2,315	330	7	330		825	12
13	CANOPY UPGRADE SPRINKLER	2006	4,866	695	7	695		1,738	13
14	WEST STEPS RETAINING WALL	2006	700	100	7	100		250	14
15	SPRINKLER SYSTEM REPAIRS	2006	1,524	218	7	218		545	15
16	LAUNDRY PLUMING UPGRADE	2006	1,840	263	7	263		657	16
17	ROOM 12 REMODEL	2006	926	132	7	132		330	17
18	SIDEWALK	2007	1,008	144	7	144		216	18
19	WATER LINE REPAIRS	2007	3,300	471	7	471		707	19
20	NORTH END FIRE DAMPERS	2007	11,784	1,683	7	1,683		2,525	20
21	KITCHEN REMODEL	2007	92,132	12,960	7	12,960		19,541	21
22	WATER LINES WEST WING	2007	1,234	176	7	176		264	22
23	BASEMENT DOORS	2007	2,605	372	7	372		558	23
24	SIDEWALK DOOR H	2008	16,218	811	10	811		811	24
25	FRONT SEWER REPAIR	2008	4,216	211	10	211		211	25
26	EXIT LIGHT UPGRADE	2008	1,089	77	7	77		77	26
27	REPIPING KITCHEN HOT WATER	2008	1,658	118	7	118		118	27
28	KITCHEN DOORS	2008	12,848	917	7	917		917	28
29	ROOM 9 REMODEL	2008	2,289	163	7	163		163	29
30	SOUTH BASEMENT UPGRADE	2008	3,404	243	7	243		243	30
31	ACTIVITY CANOPY SPRINKLER	2008	1,295	92	7	92		92	31
32	BASEMENT SEWER IMPROVEMENT	2008	4,282	305	7	305		305	32
33	PLUMBING UPGRADE	2008	6,072	433	7	433		433	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,713,066	\$ 131,244		\$ 131,244	\$	\$ 2,153,596	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,713,066	\$ 131,244		\$ 131,244	\$	\$ 2,153,596	1
2	2008	1,075	76	7	76		76	2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,714,141	\$ 131,320		\$ 131,320	\$	\$ 2,153,672	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME # 0021493 Report Period Beginning: 01-01-08 Ending: 12-31-08

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 330,374	\$ 60,051	\$ 60,051	\$		\$ 274,441	71
72	Current Year Purchases	91,039	9,104	9,104			9,104	72
73	Fully Depreciated Assets	680,283					680,283	73
74								74
75	TOTALS	\$ 1,101,696	\$ 69,155	\$ 69,155	\$		\$ 963,828	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trips	Ford Bus	1999	\$ 49,239	\$	\$	\$		\$ 49,239	76
77	Resident Trips	Ford Montana Minivan	2005	12,500	2,500	2,500			8,750	77
78										78
79										79
80	TOTALS			\$ 61,739	\$ 2,500	\$ 2,500	\$		\$ 57,989	80

## E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,913,451	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,975	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 202,975	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,175,489	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	DUPLEXES	\$ 2,720,717	\$ 89,865	\$ 773,019	86
87	COUNTRY VIEW APARTMENTS	1,097,269	23,426	220,561	87
88	DUPLEX FURN & FIX	70,580	9,558	49,564	88
89	COUNTRY VIEW FURN & FIX	108,036	10,312	80,116	89
90	DUPLEX LAND IMPROVEMENTS	368,681	25,465	135,354	90
91	TOTALS	\$ 4,365,283	\$ 158,626	\$ 1,258,614	91

## G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NONE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>    X    </u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist	NONE	hrs	\$		\$	\$									1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	<b>TOTAL</b>			\$		\$	\$		\$		\$		\$			14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME# 0021493Report Period Beginning: 01-01-08

Ending:

12-31-08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12-31-08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (79,305)	\$	1
2	Cash-Patient Deposits	856		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	538,904		3
4	Supply Inventory (priced at )	20,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,455		6
7	Other Prepaid Expenses	(1,156)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 500,754	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,603		13
14	Buildings, at Historical Cost	6,900,810		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,342,051		16
17	Accumulated Depreciation (book methods)	(4,436,558)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,930,906	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,431,660	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 146,303	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	856		28
29	Short-Term Notes Payable	487,180		29
30	Accrued Salaries Payable	212,485		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	629		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 847,453	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	616,419		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<b>DUPLEX EQUITY</b>	2,413,019		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,029,438	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,876,891	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 554,769	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,431,660	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>933,299</b>	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>933,299</b>	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(686,580)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	308,050	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (378,530)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>554,769</b>	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning: 01-01-08

Ending: 12-31-08

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,440,410	1
2	Discounts and Allowances for all Levels	(875,662)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,564,748</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,195	13
14	Non-Patient Meals	9,204	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 19,399</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	530	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 530</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		<b>27</b>
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,584,677</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,066,301	31
32	Health Care	1,925,649	32
33	General Administration	833,024	33
<b>B. Capital Expense</b>			
34	Ownership	403,165	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	43,118	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,271,257</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(686,580)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (686,580)</b>	<b>43</b>

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning:

01-01-08

Ending:

12-31-08

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,736	2,028	\$ 64,013	\$ 31.56	1
2	Assistant Director of Nursing	1,451	1,618	41,979	25.94	2
3	Registered Nurses	12,536	13,616	360,781	26.50	3
4	Licensed Practical Nurses	5,327	5,707	148,172	25.96	4
5	CNAs & Orderlies	58,523	62,508	852,983	13.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,344	4,728	93,829	19.85	8
9	Activity Director	1,914	2,129	30,077	14.13	9
10	Activity Assistants	5,027	5,595	57,866	10.34	10
11	Social Service Workers	3,215	3,525	44,069	12.50	11
12	Dietician					12
13	Food Service Supervisor	1,846	2,080	40,234	19.34	13
14	Head Cook	7,358	7,967	91,961	11.54	14
15	Cook Helpers/Assistants	13,409	13,966	130,924	9.37	15
16	Dishwashers					16
17	Maintenance Workers	2,097	2,350	59,281	25.23	17
18	Housekeepers	12,125	12,954	120,841	9.33	18
19	Laundry	5,832	6,355	70,151	11.04	19
20	Administrator	1,842	2,080	72,632	34.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,811	9,587	135,953	14.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,735	1,994	28,462	14.27	33
34	TOTAL (lines 1 - 33)	149,128	160,787	\$ 2,444,208 *	\$ 15.20	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number APOSTOLIC CHRISTIAN HOME

# 0021493

Report Period Beginning: 01-01-08

Ending: 12-31-08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Richard D. Isaia	Administrator	none	\$ 72,632	Workers' Compensation Insurance	\$ 68,433	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	176,538	Health Care Worker Background Check			
				Employee Health Insurance	279,241	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*					
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 72,632						
(List each licensed administrator separately.)									
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Health Outcomes Mgmt.	Comp. Services		\$ 7,740						
Heinold - Banwart	Acctg. Services		4,881						
Bob Rein - CPA	Acctg. Services		2,938						
Route 24 - Computers	Comp. Services		1,338						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 16,897	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. LSN-\$2,698, AAHSA-\$1,092
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,876 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,490  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 9,204
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NONE  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.